CHAPTER 1
ADDENDUM B

FIGURES

FIGURE 1-B-1 SUGGESTED WORDING TO THE BENEFICIARY CONCERNING RENTAL VS. PURCHASE OF DME

"We have determined under the Regulation that the total TRICARE benefit allowable, subject to usual deductible and cost-sharing requirements, is $_____. This amount is equal to (the allowable purchase price of the equipment) (____ months of estimated medically necessary rental, at $_____ allowable rental per month).

"You may obtain this equipment under any arrangement you wish. However, it would be advantageous for you to obtain the equipment by (rental) (purchase or lease/purchase). Any expenses you incur in excess of the TRICARE-allowable amount will be your own responsibility.

"If you are not satisfied with the action taken on your case, you have the right to a review. Your written request for a review must state the specific matter with which you do not agree and must be received in this office within 90 days of this notice.

"Accordingly, TRICARE payments for this equipment will end with whichever of the following occurs **first**:

1. When $_____ has been reimbursed, subject to usual deductible and cost-share amounts.
2. When you no longer require the equipment medically.
3. When your TRICARE eligibility ends."

FIGURE 1-B-2 ATTESTATION STATEMENT

ATTESTATION STATEMENT

TRICARE BONUS PAYMENT

The provider indicated below is eligible under the Medicare Health Professional Shortage Area (HPSA) quarterly bonus payment for services rendered in zip code(s) and has attached copy of the most recent remittance from Medicare supporting the Medicare quarterly payment. When the provider no longer qualifies for the quarterly Medicare payments, the provider shall notify the TRICARE contractor within thirty (30) days from the date the provider no longer qualifies. Notification should be made by certified return receipt. No appeal rights are available under the TRICARE Bonus Payment System other than normal payment reconciliations and verifications.

(**Provider Name**) hereby attests to be a qualified provider under the Medicare HPSA quarterly payment system and shall abide by the above provisions. Providing false information on this statement, or any subsequent withholding of relevant information, is considered a form of Program fraud pursuant to 32 CFR 199.9 and may lead to administrative and/or legal sanctions.

Provider Name: _____

Provider Number: _____

Provider Address: _____

Provider County: _____

Signature (Authorized Provider or Agent): _____

Date: _____

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